VROON VANDENBERG LLP

Catalysts for Quality Community Life

The Professional Child and Family Team Process Facilitator:

The Basics of the Child and Family Team Practice Model

Day Four of Four

DAY FOUR SCHEDULE

Safety Planning

Learner Objective: will learn steps of safety planning and can demonstrate implementation in development of initial safety plan for participant youth.

Collaboration

Learner Objective: can identify factors that lead to successful collaboration; will develop action plan for improving collaboration with system partner.

Facilitators and Meeting Management

Learner Objective: will learn basic facilitation skill set and practice redirection skills with challenging team members.

Transition

Learner Objective: will learn criteria for discontinuation of child and family team facilitation.

New Research on Wraparound Effectiveness

Learner Objective: acquaint training participants with exciting new research on wraparound effectiveness.

Questions from day three and evaluation results

SAFETY PLANNING

When should safety plans be developed? Safety plans should be developed when there is solid evidence of past unsafe behaviors by the one family member toward others, or toward themselves that create high risk. Safety plans address the question, "What actions need to be taken to ensure a safe and stable environment for the youth and family?" Safety plans in the CFT process will most often address youth who present high risk behavior. However, safety plans may also be developed to protect children from high risk behavior on the part of adult caregivers or other family members.

If a youth has a substantiated history of serious sexual aggression or is clearly identified as a potential danger to community or self, it is critical to develop a safety plan that addresses these risks. Community placement of children who offended against other children or the community must be done with the highest levels of concern for the safety of the community, the family, and the child.

Safety plans should be developed when community concerns over safety are threatening the chances that a child may remain in their community.

"Better safe than sorry". If a family member or a professional has a gut level sense that safety is an issue, then a safety plan should be developed after consultation with a professional who is qualified to determine if a child is a potential or an actual offender.

Who develops safety plans? Ideally, safety plans are developed by the child and family team working with a CFT facilitator or another professional with experience writing safety plans. It is sometimes awkward to include persons who have been responsible for committing high-risk behaviors in the planning session, but it is critical to attempt to have plan ownership by the youth in question. Safety plans are always reviewed by a professional who is qualified in the treatment of children who have offended against others.

What are the characteristics of good safety plans?

Good safety plans are both *proactive* and *reactive*. In other words, they include a preventive approach to unsafe behaviors or situations, but also include a plan about what to do if the unwanted behavior is attempted or actually occurs. At critical points, adults often do not know what to do. It is important that a good

safety plan clearly define roles, responsibilities, and required actions for each individual responsible for implementing the safety plan. The plan should also include a back-up plan should the primary plan fail when the dangerous behavior occurs.

All plans start with a recognition that no plan can prevent 100% of dangerous behavior. However, a well-constructed and carefully implemented and monitored safety plan can promote a very safe environment for the youth, the family, and the community.

The Step of Safety Planning:

Step One: Clearly describe the situation
Step Two: Start with clarifying goals
Step Three: Define inappropriate and appropriate behaviors.
Step Four: Establish family and community rules.
Step Five: Be proactive about educating siblings and others.
Step Six: Plan for community safety.
Step Seven: Plan for the 24 hour day.
Step Eight: Have a back-up plan
Step Nine: Create a proactive plan for negative community reactions.
Step Ten: Support and build the family through teaching healthy alternatives through the CFT process.

An Example: A Safety Plan for Living with a Child Who Sexually Acts Out Against Young Children

Step One: *Clearly describe the situation*

Billy is 14 years old. Billy lives with his parents, Susan and Sam, and with his younger brother and sister (ages 8 and 9). Billy has a history of acting out behaviors and problems at school. When he was 9 years old, he was sexually molested by a neighbor who was convicted of the crime and imprisoned for 25 years. When Billy was 10, he was found attempting to have sexual intercourse with his younger sister (age 7 at the time). His mother and father arranged treatment for him with a specialist who works with children with sexual acting out behaviors.

Several months after therapy ended, he was found in bed with his sister. He repeatedly exposed himself by coming out of the bathroom partially exposed. His parents were terrified of what he might do, and asked the local child welfare office

for help. The worker who assisted the family did home visits and found that Billy engaged in many "grooming" behaviors towards both his younger sister and brother. Out of fear of harm to the siblings, child welfare worked with the court (Judge Bishop), who helped place him in a group home.

After six months in the group home, Billy was ready for discharge. The Judge allowed his release since Billy's parents were willing to have him come home. They were justifiably concerned about their other children, and the reaction of the community.

The CFT worker had been trained in developing safety plans and worked with the family and the child welfare worker (Nevel Jameson) to develop a plan for Billy and his siblings, his parents, and the community.

Here is the finished plan with instructions in italics:

Step Two: ***Start with clarifying goals***

Statement of expectations / goals: Billy will exhibit no sexual behaviors toward the young children living in the house.

Step Three: ***Define inappropriate <u>and</u> appropriate behaviors***

Definition of inappropriate sexual behaviors by Billy:

1. Having the young children sitting on his lap
2. Touching his own genital area in the proximity of the children
3. Sitting or lying on the bed of the children
4. Touching the children except when playing contact games, and particularly not in genital areas, buttocks or in breast areas for girls
5. Talking about sexual matters around the children
6. Showing sexual pictures or drawings to the children
7. Tell stories with sexual connotations to the children

Definition of appropriate sexual behaviors by Billy:

1. Touching his genital areas when he is alone in the privacy of the bathroom or when alone in room
2. Having sexual feelings toward girls his own age or older (Billy was evaluated as being heterosexual)

Step Four: ***Establish family rules***

Family rules for contact between Billy and the children:

1. Billy is never to be alone with the children except in the event of an emergency.
2. Billy is allowed to play with the children in appropriate ways such as card games, Nintendo, or watching television or listening to music. When Billy needs clarification on whether or not a game is appropriate, he will ask Susan or Sam. Billy is not to make these decisions on his own.
3. Susan or Sam will give Billy frequent feedback if they feel that he is beginning to violate rules regarding contact with the children or with inappropriate sexual behaviors.
4. Billy is not ever allowed to play with children from other families without supervision. He is not allowed to enter houses without adult supervision, where other children may be present.

Step Five: *Be proactive about educating siblings*

A proactive plan to educate children about safety issues:

1. Beth Sampson (therapist at the mental health center) is a certified expert teacher of good touch / bad touch curriculum for young children. She will give the two children extensive lessons in good touch / bad touch.
2. She will give four follow-up refresher sessions at one month intervals.
3. Beth will join the child and family team for at least six months and will be available to Nevel Jameson or to the parents as needed.
4. Susan and Sam will do frequent reminders with the children about what they have learned.

Step Six: *Plan for community safety*

Billy is not allowed to "hang around" the younger children in the neighborhood unless adults are with him. At school, he will not be allowed to play with the younger kids. For the first six months of his plan, one of his parents will drive him to school, escort him inside, and pick him up after school. It may be necessary to hire an aide through the CFT process to supplement parent time as needed.

Step Seven: *Plan for the 24 hour day*

Plan for night hours:

As 24 hour care is not possible, a motion detector will be placed outside of Billy's bedroom. He will call to Susan or Sam if he has to go to the bathroom so that they can disable the detector and reset it after he returns to his bedroom. This part of the plan will be in place for at least six months, then evaluated for continued need.

In addition, the children will be trained to scream loudly if any one other than their parents enters their room at night. Each child will be trained in the use of an alarm buzzer mounted at the side of their beds. Practice sessions will be held to help train the kids in the procedure. The materials for the buzzer, and the motion detector can be purchased at Radio Shack.

Step Eight: *Have a crisis back-up plan*

If Billy should violate the rules of inappropriate sexual behaviors:

Nevel Jameson (child welfare worker) will be notified immediately. Billy will be removed from the home and placed in the Jones shelter while an investigation is completed. If necessary, due to severity of the violation, Billy will be placed in detention for one to three weeks. If the violation involves direct sexual contact with children, Nevel will contact Judge Bishop who will advise the team and recommend action.

Plan if Sam and Susan are not sure if Billy has violated a rule:

They will call Nevel and ask for a clarification and a decision. If Nevel is unavailable, they can call Susan Pierce (child welfare worker) as a back-up.

Nevel will conduct home visits and monitor the safety plan implementation. This will be done at least every month for the first six months, and then quarterly thereafter.

Step Nine: *Create a proactive plan for negative community reactions*

If a community member believes that Billy does not belong in the community and begins to cause concerns to be developed by other community members:

Nevel will obtain a copy of the court order allowing Billy to live at home. If Billy reports harassment or if community members complain to Susan or Sam, they will refer the complainant to Nevel, who has court and family permission to show them the order. If for any reason Billy's safety is in question, Sam or Susan will increase supervision of Billy outside of the home. The police will be called if necessary.

Step Ten: ***Support and build the family through teaching healthy alternatives***

Plan for using the CFT process to support Billy and his family, and to teach him positive alternatives to deviant behaviors:

The parents will help create a plan that addresses Billy's needs and those of the other family members. Family members' strengths will be used to develop the plan. For example, since Billy is quite athletic, sports may be included in the plan as an outlet for him. The plan will reflect other family members interests similarly, and include them as methods of creating opportunities for family engagement in positive activity.

Remember: monitor, document, ask for help if needed.

It is important to note that Nevel and the CFT process facilitator are planning to hold weekly monitoring meetings for the first six weeks of the plan, and then to have meetings at least once a month for one year. Documentation duties will be assigned, and careful daily records kept by Susan and Sam. They will send the records to Nevel weekly. Sam and Susan will ask for help when they feel that they need it.

Small Group Exercise: In groups of about four, appoint a recorder and a reporter. Using the experiences of small group members, choose a problem behavior that would merit the development of a safety plan – an actual high risk behavior one of the group members is currently working with is best. As a group, develop a safety plan according the safety planning steps that are reviewed below. If a step does not apply, skip it and go on to the next step. Be prepared to discuss your work in the large group. (time: 30 minutes)

The Steps of Safety Planning Reviewed:

Step One: Clearly describe the situation
Step Two: Start with clarifying goals
Step Three: Define inappropriate and appropriate behaviors

Step Four: Establish family and community rules
Step Five: Be proactive about educating siblings and others
Step Six: Plan for community safety
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COLLABORATION BETWEEN AGENCIES AND SYSTEMS

Definitions of collaboration:

"Collaboration is an unnatural act between non-consenting adults." *Anonymous*

"To cooperate with an enemy who has invaded one's territory." *Webster's (1)*

"To work with others toward a common goal." *Webster's (2)*

Collaboration with other professionals from other systems can be a difficult and challenging process. While this is sometimes due to a difficult personality of an individual we are working with, we think challenges to collaboration are often due to a failure to recognize the strengths, needs and culture of the systems we partner with in working with youth and families with multiple system needs.

The Strengths, Needs and Culture of Agencies and Systems

Agencies and systems have unique strengths, needs and culture just like youth and families. A facilitator is most effective promoting effective inter-agency or inter-system collaboration if he or she actively seeks to learn and understand the strengths, needs and culture of agencies and systems involved in the CFT process.

One of the primary determinants of a system's strengths and culture are the societal and legal mandates of the system. For example, our society has a value that communities should protect children. The child welfare system is responsible for carrying out this important value, i.e., the societal and legal mandate of the child welfare system is to ensure the safety of the children in our community. The societal and legal mandate, child safety, shapes the design of the child welfare system and the behavior of its workers.

If the facilitator recognizes the societal and legal mandates of each child serving system and understands how these mandates shape the design of the systems and the behavior of their workers, the facilitator can be more effective managing the CFT process so its addresses the needs of the youth and family *and* the needs of involved system partners.

Societal and Legal Mandates of Child Serving Systems

Below is a list of primary child serving systems and their corresponding societal and legal mandates:

System	Mandate
Child Welfare	Safety
Juvenile Justice	Community Protection
Education	Learning
Mental Health	Emotional Health (traditional mandate)
Developmental Disabilities	Habilitation
Public Health	Disease Prevention

What Facilitators can do to Foster Collaboration

We see the CFT facilitator as a key quality control point for ensuring that our value of collaboration is carried out in a community system of care. Some of the ways that those values are carried out are:

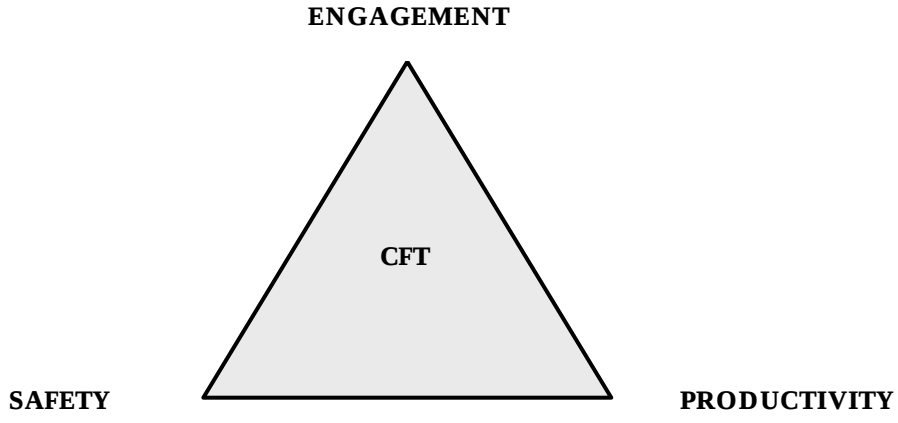
1. Learn about societal and legal mandates of each system and the culture of each system.
2. Serve to model good cross-system regard. CFT supervisors set the tone in the agency for a strengths-based communication strategy for all cross-system interaction.
3. Encourage supervisor to supervisor interaction between systems.
4. Hold "get to know you" sessions between systems (snacks!).
5. Set up learning opportunities to share information between systems.
6. Get frequent feedback from other system staff who are child and family team members. Are their needs being met?
7. Involve other systems in evaluating the CFT process.

Small Group Exercise – Part One: *In a small group of others you work with*, appoint a recorder and reporter. Your trainer will assign a child-serving system for your small group to discuss. Make a list of the characteristics that describe that system's behavior and culture. For example, if your group is discussing juvenile justice, someone might say that system operates from a "power and control" perspective or "that there is an emphasis on accountability". Make as comprehensive a list as possible in the time allotted. The reporter from your group will summarize the list in the large group. (time: 20 minutes)

Small Group Exercise – Part Two: In the same small group, develop an action plan for how to improve collaboration with the system your group feels has the greatest need for improved collaboration. What are some realistic action steps that you personally or as a group can take in the next month that will result in improved collaboration between your agency/system and the agency/system your group has selected. You will be asked to share the highlights of your action plan in large group. (20 minutes)

FACILITATORS AND MEETING MANAGEMENT

The CFT facilitator is responsible for developing a culture at the child and family team level that supports the development of plans that reflect the core values of the CFT process, the timely implementation of the plan, and the careful evaluation of the effectiveness of plan options in meeting priority needs. Facilitators must establish an effective foundation for the work of the child and family team. Elements of this foundation include: engagement, safety, and productivity.



Engagement (at the child and family team level)

Once a child and family team convenes, a facilitator must foster engagement of the participants as a group. That is to say, the facilitator works to establish rapport among team members and an environment of trust. Though team members may not know one another, the facilitator punctuates that they all share a common bond in that they know the family well and care about their well-being. Members also don't know what to expect. The facilitator fosters engagement by facilitating introductions and reprising the purpose of the team. While the needs of the youth and family may be great, the facilitator shows enthusiasm and cultivates hope.

Safety

The culture of the child and family team must reflect the value of safety. Ground rules are an important method for establishing a safe team work environment. Team members may be afraid they will be criticized or "shamed and blamed". Ground rules that support the value that "everyone's ideas are good ones" and that the process will be "strength-based" address these fears.

Productivity

Finally, the facilitator's role is to ensure that the job gets done. The team has convened to develop a plan to assist the youth and family to meet priority needs. While the facilitator must be sensitive to the pace of the team – neither moving too quickly nor too slowly – a viable plan must be developed, implemented, and evaluated to determine its effectiveness in achieving desired outcomes. Child and family team members must experience the team process as one where important things are accomplished, or their motivation to continue to participate will diminish.

Basic Skills of Facilitation

- **Active Listening** – eye contact, mannerisms, etc.
- **Attention to Feelings** – e.g., "How to you feel about that option?"
- **Give Recognition** – use names, give thank yous, celebrate successes
- **Paraphrase** – clarify or summarize a person's statement
- **Review** – review where the team has been in the conversation; review key options and team member commitments; review progress
- **Build Consensus** – ensure the whole team supports goals and options
- **Encourage Participation** – help even quiet team members to share without forcing participation

- **Resolve Conflict** – help disagreeing team members find areas of common ground, e.g., help them recognize the need they are trying to meet; recognize when there is a deeper conflict (old resentment) and have someone competent to address this issue outside the meeting – *a child and family team is not a therapy session!*
- **Facilitate According to the Steps of the CFT Process** – know what step of the process you are on and what's next
- **Advance Preparation** – consider what you want to achieve in the meeting *before the meeting starts*
- **Monitor the Process Against the Values/Principles** – is the process individualized, competent to the culture of the youth and family, strength based, leveraging natural supports?
- **Transfer Leadership** – work yourself out of a job; prepare another team member to take over the facilitation role

Managing Challenging Behavior in CFT Meetings

Sometimes team members present challenging behavior that is an impediment to achieving the goals of the CFT process. These behaviors must be addressed swiftly and effectively in order to develop and maintain an effective child and family culture. An angry professional can derail the entire process, or an out-of-control parent may stop any progress from occurring.

What follows are some of the most common challenging behaviors as well as potential solutions:

1. **Late team members.** Use the teaming process to discuss what should be the team commitment around being on time.
2. **Team members with other agendas.** It is common for a team member to come into the meeting with a hidden agenda, such as get the team to agree to placement, or to close the case. The facilitator must actively and proactively deal with this issue by "sniffing" out those who may come loaded with hidden agendas. Call them in advance and ask what they want out of the meeting, then put their issue on the table at the start of the meeting, and ask the team if they want to deal with that today. Or, ask them to hold their agenda because it conflicts with the direction of the team.
3. **Team members who never learned to work as a team.** Unfortunately, some team members truly are not team members – they are used to making decisions on their own and want to do what they wish. They may feel that the team process is an impediment to getting their job done. The facilitator must deal with this through lots of team building. For example, start slow and get a

success or two under the team's belt. Perhaps take an extra meeting just to let team members introduce themselves and share personal stories. In addition, the facilitator has to coach these types of team members individually and as a group.

4. **Team members who don't listen.** Unfortunately, some team members just never learned to listen to others. This may cause others to feel a sense of disrespect. Check to see if this is a cultural issue. You may ask the non-listening team member to take notes on what others are saying. You may represent or advocate for the points made by those who were not listened to.
5. **Team members who are burned out.** It is common for high caseload individuals to be a bit "fried" on the job. The facilitator should sympathize, but also keep the meetings brief, and build a phone or email relationship with the "fried" ones. Cultivate a relationship with them. Honor their strengths, expertise and achievements.
6. **Team members who don't understand family voice and choice.** Unfortunately, family members are often given voice and choice up to the point that the professional disagrees with the family. In the early stages of the CFT process in a community, many professionals who don't understand the value of parental and youth voice and choice will be shocked to discover that family driven means, well, family driven. The facilitator is the person who stands up for the values of the CFT process.
7. **Team members who are angry with the family.** These team members most often will attempt to belittle the family or lecture them about their responsibilities. These team members can be very destructive to the process. The facilitator should not allow blaming and shaming, ever. Stop the meeting, stop the presses, just stop the abuse! The facilitator must keep the environment safe for all team members.
8. **Teens who don't like being there.** What a shock! Some teens in the CFT process don't like to sit in meetings. Have another teen in the meeting to provide support; offer to tape the meeting for the teen and for you to review later (they never go for this more than once). Set ground rules for the teen to stay in the meeting.

Small Group Exercise – Role Play: Return to the small groups where you last role played crisis planning. Choose one of the difficult behaviors listed above, or think of another challenging behavior you have experienced. Spend a few minutes detailing the context of the challenging behavior, so the role play has sufficient foundation. Assign roles based on the context of the challenging behavior you have chosen with one person taking the role of facilitator. If possible, assign one person to the role of observer. After the role-play, discuss what worked. The observer should give the facilitator feedback. Then, switch roles so another person

in the group has an opportunity to be in the facilitator role and repeat the scenario and feedback process. Once you have "maxed out" the scenario, develop another one so that everyone in the group has had a chance to practice challenging behavior management in the facilitator role. We will debrief in large group. (time: 25 minutes)

CHILD AND FAMILY TEAM PROCESS STEP EIGHT: TRANSITION

The last step of the CFT process is transition out of the CFT process and potentially from all formal services. One emphasis of the CFT process is the identification and mobilization of informal supports and resources to support children and families. Enlisting their participation on the child and family team sets in motion a process whereby families may transition out of the CFT process with a support team that will continue to be available to the youth and family after the CFT facilitator is gone.

Traditional service systems' near exclusive emphasis on professional service providers may support dependence at worst and certainly does not provide for ongoing mechanisms of support after the professionals close their cases and are gone. The result too often is youth and family relapse and recidivism and reentry to the formal services system. The revolving door metaphor is one we are all familiar with.

How does the CFT facilitator know when to begin the gradual process of discontinuing formal facilitation with the youth and family? There are several guidelines to follow:

- *Once there are sufficient informal supports in place, transition is more likely to be successful.* A child and family team composed mostly of paid professionals does not indicate readiness for transition. Here again, there are not adequate informal supports for the family after transition out of the CFT process. The facilitator will need to work toward the increased participation of informal support persons on the team. For families who have burned out their extended family and other informal supports, the facilitator may need to develop family advocates or parent mentors to assume this function. Child and family teams that are composed of at least 50% informal support persons are better prepared for transition.

- *Youth and families that have assumed facilitation responsibility for their child and family team meetings are approaching readiness for transition*. Facilitators' ultimate goal is to help family members assume more and more responsibility for managing their child and family teams including becoming their own facilitators. Alternately, another child and family team member who is not a paid professional may be groomed to take over the facilitation role. Youth and families who become their own facilitators may also be recruited later to facilitate other families.

- *When priority goals have been achieved and are supported by the tracked data, transition should be considered.* Facilitators track data in order to determine if progress toward goals is occurring and when terminal change benchmarks have been achieved.

When a youth and family and their child and family team have developed to the point where all of the above conditions have been met, transition is probably overdue. The skilled CFT facilitator begins to discuss the goal of transition out of the CFT process and the potential for transition out of the formal service system early in the course of the relationship with the youth and family and subsequently with the child and family team. Most families, if assured of sufficient informal support, are eager to end relationships with the CFT facilitator and other representatives of the formal service system. This goal then, transition out, is a secondary goal of the CFT process from its initiation.

NEW RESEARCH ON WRAPAROUND EFFECTIVENESS

Introduction

The use of "wraparound" as a service process has steadily increased over the past fifteen years and recent estimates are that as many as 400,000 children and youth may have received "wraparound" (VanDenBerg, 2003). Multiple demonstration projects have reported successful reductions in the number of days and level of restrictiveness of residential placements using a "wraparound" approach. These and other demonstrations have shown improved school, social, emotional, and behavioral functioning for children and youth and improved quality of life and empowerment to meet the needs of their own children for parents using a "wraparound" approach (VanDenBerg, 1993, Rast, 1999, Burns 2002). Although these demonstrations have included thousands of children, they have not met the criteria of "evidence-based" because they have been demonstration projects and not controlled research. This paper reports on the pilot phases of a research

process in Nevada to evaluate the impact of the wraparound process for several hundred children in the child welfare system.

The Nevada Wraparound Pilot

This pilot project is part of legislation that is changing the child welfare system in Nevada and would not have occurred without this legislative mandate. The context and history of this legislation may serve as a guide to others who want to evaluate promising practices to establish evidence-based results of the practices effectiveness. In 1998 Nevada was the only state in the country that still had a bifurcated child welfare system in which the counties did investigations and child support while the state did foster care and adoption. It was decided that this was causing bad outcomes for children and families and created duplication and fragmentation of public services. A legislative committee was formed to decide how to make a change. Some of the steps taken that may have influenced the final legislation were:

1. Mental Health staff and advocates became active participants in this planning process (devoting thousands of hours of time and resources) to ensure that the new system met the behavioral health needs of the children and youth.
2. Families and staff told multiple stories of how unmet mental health needs had led to bad outcomes for children and youth in the child welfare system and stories of how effective mental health supports (through SAMHSA System of Care project) had led to good outcomes.
3. Division of Child and Family Services (DCFS) staff evaluators in Las Vegas completed an assessment of the number of children in the foster care system who had mental health needs and how many of these children were not receiving appropriate levels of services.
4. National experts were brought in to testify on the impacts of implementing Systems of Care and to work with the legislative committee on designing how this could occur in Nevada within the context of the proposed changes in the child welfare system.
5. DCFS staff and evaluators presented data on the positive impact of System of Care and Wraparound implementation for children within the Neighborhood Care Center Project.

The final result was child welfare legislation that established collaborative Mental Health Consortia in each jurisdiction of the state whose role is to annually assess the current need for children's behavioral health services, to assess how well this need is met, to develop a plan for how this need can best be met, and to communicate this to a newly formed standing committee of the legislature. In

addition, the legislation created funding and flexibility to provide comprehensive wraparound services for 327 children in the child welfare system and mandated an evaluation of the impact of this service process with quarterly reports to the Legislative Committee on Children and Youth. The mandate of the services and evaluation for these children kept this project ongoing through tough economic times.

Method

The subjects for the pilot phase of this research project were 65 children and youth in the child welfare system that met the criteria for severe emotional disorders (SED). Thirty-three of the children were assigned to the "experimental" group and 32 were assigned to the "control" group. Through a statewide assessment process over 400 children were identified who met the basic criteria for the initial services. It was decided to do the initial pilot work in four areas of the state (Reno, Carson City, and North and West Las Vegas). Eight children were selected from this list of 400 children in each of these regions and a ninth from North Las Vegas was selected to receive the wraparound process. In each of these areas eight children were selected to serve as controls. These children were matched on age, sex, race, current residential placement, severity of mental health problems as measured by the CAFAS and the GAF. See Table One below for the comparison of these two groups.

	Control	Experimental
Age	11.7 years	11.9 years
% Caucasian	51.9%	54.2%
CAFAS	103	102
GAF	48	46
Residential Level	3.4	3.2
Moves Last 6 Months	1.9	2.4
Days in Custody	1318	851

Table One shows a comparison of the 65 subjects (33 experimental and 32 control) at time of intake. The average age is shown in years. The race shows the percent of each group who were Caucasian. The CAFAS scores are the average using the 8 scale scoring system. The GAF (global assessment of functioning) scores were done at time of entry into the study. The residential level is based on the ROLES (Restrictiveness of Living Environment Scale) levels adapted for Nevada in which higher levels are more restrictive. The moves are the number of changes in primary residence in the 6 months prior to initiation of the study and the days in custody is the number of days the child had been in the custody of the state at the date of study initiation.

The thirty-three children and youth in the experimental group were assigned to one of four wraparound facilitators who were trained in the wraparound process. Each of these wraparound facilitators also received hands-on coaching as they learned and began to implement the process. The quality of the wraparound process was measured using the wraparound fidelity index (WFI)[1]. Children and youth in the control group received the standard child welfare and mental health services available in the system[2].

The evaluation for this study has three primary parts: a child and family-outcome study, process assessment, and services and costs. Some of the initial findings for the child and family-outcome study are presented below. Data is being collected in the following areas: child symptoms and intensity and substance abuse (CAFAS); child behavior (CBCL), social functioning; substance use; school attendance and performance; delinquency; juvenile justice involvement (Nevada Child Status Report); and stability of the child's living arrangements (modified ROLES). This evaluation component gathered information on children for the six months prior to study implementation.

[1] Implementation and the results of the process measures using the WFI are described in a separate paper by Rast, Peterson, Earnest, and Mears (2003) entitled, "Service Process as a Determinant of Treatment Effect – the Importance of Fidelity".

[2] The differences in what children received is being documented and analyzed through a services and costs study not reported in this symposium.

Results

The initial results show some large improvements in many of the primary outcome measures for the children and youth receiving wraparound. Figure One below shows the changes in residential placement for the two groups of children after six months. Thirteen of the 33 children who received wraparound moved to less restrictive environments compared to only 3 of the 32 controls. In addition, 7 of the 32 controls moved to more restrictive placements compared to only 3 of those who received wraparound. In fact, through the process of the strengths, needs and culture discovery, family members were found for seven children in the experimental group who had previously had permanency goals of long term foster care.

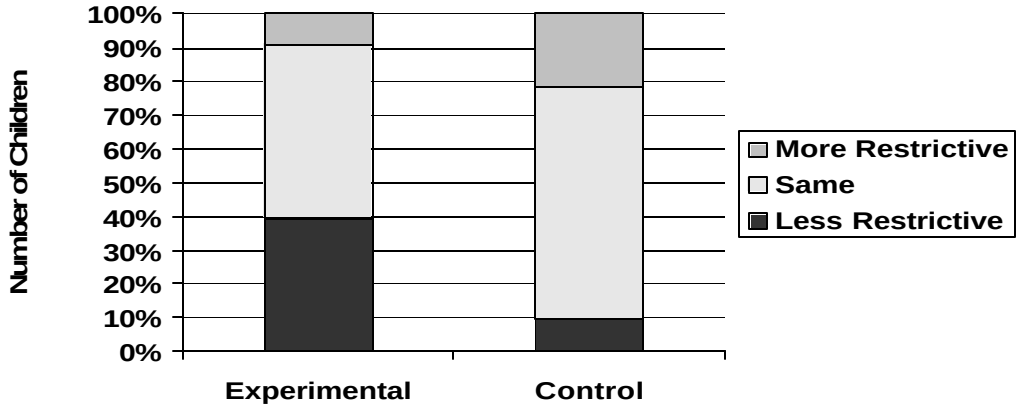


Figure One shows a comparison of residential placement level of the two groups (experimental N=33 children and controls N=32 children). The data compares the level of restrictiveness at the time of study initiation with the level of restrictiveness after six months. The levels are based on the ROLES modified to the specifics of the Nevada continuum of residential placements.

Figure Two shows three of the primary school outcomes for the two groups. Thirty of the children in each of the two groups were enrolled in school. For these children the left panel of the figure shows school attendance and disciplinary actions. In each case the children receiving wraparound had a 29% decrease in absences and a 26% decrease in disciplinary actions compared to the controls that had a 26% increase in absences and a 18% increase in disciplinary actions. The right panel of Figure Two shows the changes in grade point average. 43% of the children in wraparound had an improved GPA compared to only 17% of the controls. On the other hand, 23% of the children in wraparound had lower grades compared to only 10% of the controls.

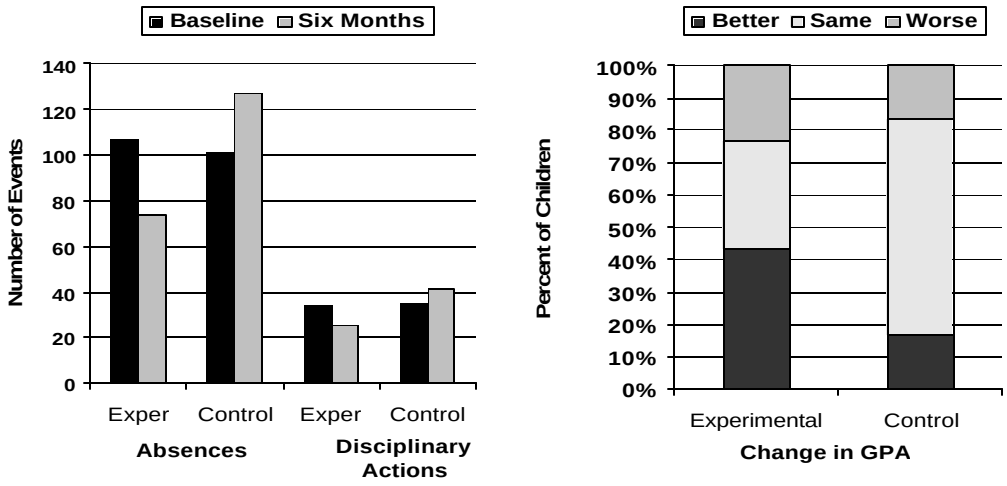


Figure Two shows the data for three school outcomes for the children in the experimental group (30) and control group (30). Absences refers to the total absences of all students in each group adjusted for the number of days of scheduled school. Disciplinary actions shows the number of detentions and suspensions for the students in each group during the same time period. Change in GPA compares the grade point average for the six months prior to study initiation with the first six months of the study. Better reflects grade point averages that increased by more than 0.1 on a 4-point scale and worse reflected GPAs that decreased by more than 0.1.

Table Two shows the results for seven of the primary outcome measures. In only four of the seven areas did the controls show an improvement while the children in wraparound showed improvement in all seven areas and more improvement in the four areas that the controls showed improvement. This is only the pilot data for the first group of children in this study but the initial results are very promising.

Measure	Control		Experimental	
	Baseline	6 Months	Baseline	6 Months
Residential Level	2.9	2.8	2.9	2.2
Abuse Reports	0.5	0.2	0.3	0.03
Law Enforcement Contacts	0.6	0.4	0.4	0.1
GPA	2.5	2.5	2.4	2.4
Absences	3.3	4.2	3.5	2.5
Disciplinary Actions	0.9	1.3	1.1	1.1

Table Two shows the summary results of some of the primary outcome measures for the study. Residential level is measured from the six levels of the ROLES adapted for Nevada. Level 1 is the level for living with family or independent living and Level 6 is psychiatric hospitalization. Abuse reports refers to the average number of abuse reports filed in the six months prior to study initiation and the number filed in the first six months of the study. The law enforcement contacts refers to the average number of contacts in the same time periods. GPA refers to the average grade point average for children in the six months prior to study initiation and the first six months after initiation. Absences is the average number of school absences and disciplinary actions is the average number of school disciplinary for these time periods.

Discussion

The development of Systems of Care and implementation of the wraparound process has been widespread throughout North America in the past fifteen years. Although there have been several single subject design studies and multiple demonstration projects that have reported positive outcomes from these processes, there is a need for controlled research. Wraparound is a real world process that must be individualized for every child and family. This need for individualization makes it more difficult to complete the needed research to define the impacts of wraparound and the differential impacts of the steps in the process. Through engaging and building on an ongoing systems change effort in DCFS, it has been possible to establish the conditions for doing this type of research. The initial results seem to show that wraparound can result in positive gains for children and youth in residential placements, primary school outcomes, and mental health symptoms.

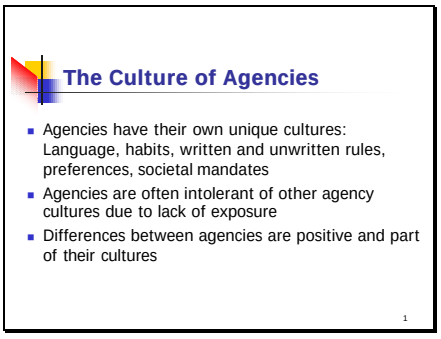
References

Burns, B.K. (2002). Reasons for hope for children and families: A perspective and overview. In Burns, B. and Hoagwood, K. (Eds.), Community Treatment for Youth: Evidence-Based Treatment for Severe Emotional and Behavioral Disorders. Oxford: Oxford University Press.

Rast, J. (1999) Promising Practices in Children's Mental Health, Systems of Care 1999 Series, Volume VII. NRN (Eds.) in Integrated Evaluation and the Development of Systems of Care. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

¤ DVD CLIP: EPILOGUE (ORA AND VANDENBERG)

Slide 1



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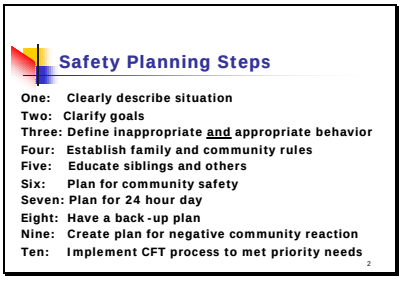

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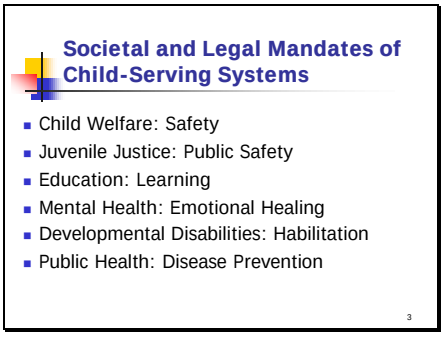


Slide 4

The Pillars of the Effective CFT

- Engagement
- Safety
- Productivity

4

Slide 5

Basic Facilitation Skills

- Active Listening
- Attention to Feelings
- Give Recognition
- Paraphrase
- Review
- Build Consensus
- Encourage Participation
- Resolve Conflict
- Facilitate Wrap Steps
- Advance Preparation
- Monitor Against Values
- Transfer Leadership

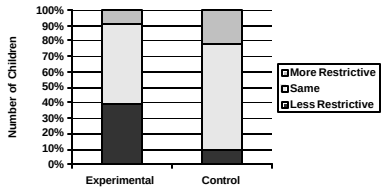
5

Slide 6

	Control	Experimental
Age	11.7 years	11.9 years
% Caucasian	51.9%	54.2%
CAFAS	103	102
GAF	48	46
Residential Level	3.4	3.2
Moves Last 6 Months	1.9	2.4
Days in Custody	1318	851

Table One shows a comparison of the 65 subjects (33 experimental and 32 control) at time of intake. The average age is shown in years. The race shows the percent of each group who were Caucasian. The CAFAS scores are the average using the 8 scale scoring system. The GAF (global assessment of functioning) scores were done at time of entry into the study. The residential level is based on the ROLES (Restrictiveness of Living Environment Scale) levels adapted for Nevada in which higher levels are more restrictive. The moves are the number of changes in primary residence in the 6 months prior to initiation of the study and the days in custody is the number of days the child had been in the custody of the state at the date of study initiation.

Slide 7



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Slide 8

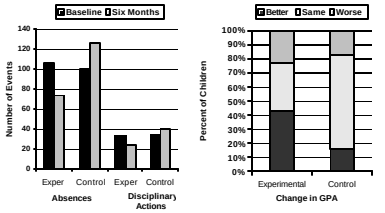

Figure Two shows the data for three school outcomes for the children in the experimental group (30) and control group (30). Absences refers to the total absences of all students in each group adjusted for the number of days of scheduled school. Disciplinary actions shows the number of detentions and suspensions for the students in each group during the same time period. Change in GPA compares the grade point average for the six months prior to study initiation with the first six months of the study. Better reflects grade point averages that increased by more than 0.1 on a 4 point scale and worse reflected GPAs that decreased by more than 0.1.

Slide 9

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WRITTEN EVALUATION FOR VVDB TRAINING		
DAY FOUR		
Areas of focus	**Rating (Circle a Number)**	**Comments**
Section and exercise on safety planning	Rate how useful this area was to helping understand meeting management: 1. Was not useful 2. May be useful, not sure yet 3. Will likely use this information on some occasions	
Section and exercise on collaboration	Rate how useful this area was to doing your job better: 1. Was not useful 2. May be useful, not sure yet 3. Will likely use this on some occasions	
Section and exercise on meeting facilitation and management	Rate how useful this area was to doing your job better: 1. Was not useful 2. May be useful, not sure yet 3. Will likely use this on some occasions	
Section on transition	Rate how useful this area was to doing your job better: 1. Was not useful 2. May be useful, not sure yet 3. Will likely use this on some occasions	
Section on wraparound effectiveness research	Rate how useful this area was to doing your job better: 1. Was not useful 2. May be useful, not sure yet 3. Will likely use this on some occasions	

RATE THE OVERALL TRAINING	
What I would add to or subtract from the overall training	

Any overall suggestions for any of the trainers? Pace, training style, materials, etc?	
Do you feel prepared to go back to work and implement the child and family team process? Comments.	
Write down the most important thing you learned from this four day training.	
Any other Comments / Needs / Suggestions?	